



## **PACKET C**

**TO BE USED BY ALL COUNTY EMPLOYEES WHO  
ARE EMPLOYEES OF THE FOLLOWING COUNTY DEPARTMENTS:**

- 1. Children & Family Services**
- 2. Fire**
- 3. Health Services**
- 4. Internal Services**
- 5. Medical Examiner-Coroner**
- 6. Mental Health**
- 7. Probation**
- 8. Public Health**
- 9. Public Social Services**
- 10. Public Works**
- 11. Sheriff**



**REQUEST FOR LEAVE OF ABSENCE**  
***Related to COVID-19***  
***Supplemental Paid Sick Leave***  
***(Labor Code § 248.1)***

**Instructions:**

1. Eligible Employees (employees who work as emergency responders and health care providers) may request a paid leave of absence related to COVID-19 under California Labor Code Section 248.1 – COVID-19 Supplemental Paid Sick Leave. A description of this leave is provided on page 3 of this document.
2. To request this leave, employees may complete the “Request Form for Leave of Absence Related to COVID-19 Supplemental Paid Sick Leave (Labor Code § 248.1).” The form is available as a PDF document or as a PDF Fillable document on the Department of Human Resources website at <https://employee.hr.lacounty.gov/directors-message-2/>.
3. Employees may submit the completed request form to their department’s Human Resources Office.
  - Employees who do not know how to reach their department’s Human Resource Office can check with their supervisor or their department’s Administrative Services Office for assistance.
  - Departmental Human Resources Offices can provide employees with an e-mail address that can be used to electronically submit the completed request form.
4. If the completed request form is being submitted electronically and the employee is unable to submit the electronic copy of the form with their signature applied, the employee may submit the completed, unsigned request form as an attachment to an e-mail from his or her work or personal e-mail address. Unsigned request forms may not be submitted from an e-mail address that does not belong to the employee. An employee's submission of a completed and unsigned request form from the employee’s e-mail address will be deemed as his or her certification of the information listed in the form.



<b>COVID-19 SUPPLEMENTAL PAID SICK LEAVE (Labor Code § 248.1)</b>	
<b>Effective Date</b>	September 19, 2020.
<b>Who is Eligible</b>	Employees working as emergency responders or health care providers who were excluded from Emergency Paid Sick Leave (EPSL) under the federal Families First Coronavirus Response Act (FFCRA).
<b>Amount of Leave</b>	<p><u>Full-Time Employees</u>: Up to 80 hours.</p> <p><u>Part-Time Employees</u>: Prorated based on the normally scheduled hours an employee works in a 2-week period or, if the part-time employee works a variable number of hours, 14 times the average number of hours the part-time employee worked each day in the 6 months preceding the date the part-time employee took COVID-19 supplemental paid sick leave.</p> <p><u>Active-Duty Fire Fighters</u>: Number of hours the fire fighter was scheduled to work in the 2-week period immediately preceding the taking of COVID-19 supplemental paid sick leave.</p>
<b>Qualifying Reasons</b>	<p>Employee is unable to work or telework, and:</p> <ol style="list-style-type: none"> <li>1) is subject to a federal, state, or local quarantine or isolation order related to COVID-19;</li> <li>2) has been advised by a health care provider to self-quarantine or self-isolate due to concerns related to COVID-19; or,</li> <li>3) is prohibited from working by the employer due to health concerns related to the potential transmission of COVID-19.</li> </ol>
<b>Applicable Offset</b>	<p>Employees working as emergency responders or health care providers who were provided with COVID Paid Leave hours for one of the qualifying reasons covered by Labor Code § 248.1 and have exhausted those hours are <u>not</u> eligible for COVID-19 supplemental paid sick leave.</p> <p>Employees working as emergency responders or health care providers who were provided with <u>unpaid</u> leave for one of the qualifying reasons covered by Labor Code § 248.1 between March 4, 2020 and September 19, 2020 are eligible for retroactive supplemental paid leave.</p>
<b>Pay</b>	<p>Qualifying employees are paid at their regular rate of pay or the current minimum wage, whichever is greater.</p> <p>Departments are not required to pay more than \$511 per day and \$5,110 in total.</p>
<b>Relationship with Other Leaves</b>	Employees are not required to use other accrued leaves prior to using this leave. Use of this leave does not count against an employee's paid leave accrual balances, such as accrued vacation leave, sick leave, etc.
<b>Request for Approval</b>	<p>Employees requesting approval for COVID-19 supplemental paid sick leave may submit the request form attached here to their department's Human Resources Office.</p> <p>When the need for leave is foreseeable, employees should notify their department's Human Resources Office of the need for leave as soon as can be arranged.</p> <p>COVID-19 supplemental paid sick leave is available until December 31, 2020, or upon the expiration of any federal extension of the Emergency Paid Sick Leave Act established by the FFCRA, whichever is later.</p>



**REQUEST FORM FOR LEAVE OF ABSENCE**  
***Related to COVID-19***  
***Supplemental Paid Sick Leave***  
***(Labor Code § 248.1)***

*In order to be eligible for this leave, you must be an employee working as an emergency responder or health care provider who was excluded from EPSL under the FFCRA and be unable to work or telework due to any of the qualifying reasons listed in Labor Code §248.1.*

Employee Name (Last, First):		Employee Number:	
Department:			
<b>Employee Information</b>			
Payroll Title:			
Personal E-mail Address		Work E-mail Address	
Home Telephone		Cell Telephone	
<b>Supervisor Information</b>			
Name		Title	
E-mail Address		Work Telephone	

**Section 1: Employee Leave Request**

**1. I am requesting the following leave:**

☐

**COVID-19 Supplemental Paid Sick Leave.**

Requested Start  
Date:

Requested End  
Date:

Type of Leave Requested (check one):

\_\_\_\_\_ Continuous

\_\_\_\_\_ Intermittent (If teleworking) - Please provide details of requested leave schedule:

\_\_\_\_\_



**2. Check one of the following:**

☐

This is my initial leave request.

☐

This is a supplemental request to extend previously approved COVID Paid Leave. If so, complete Section 3.

☐

I previously requested COVID Paid Leave and was denied, but was allowed an unpaid leave of absence.

Date of denial \_\_\_\_\_ Reason \_\_\_\_\_

Dates of unpaid leave taken \_\_\_\_\_

**3. I was previously approved for and used COVID Paid Leave. (Yes/No): \_\_\_\_\_**

I exhausted the COVID Paid Leave previously provided to me. (Yes/No): \_\_\_\_\_

Dates of Leave: \_\_\_\_\_

The COVID Paid Leave provided to me was because (check all that apply):

<input type="checkbox"/>	I was subject to a federal, state, or local quarantine or isolation order related to COVID-19.
<input type="checkbox"/>	I was advised by a health care provider to self-quarantine or self-isolate due to concerns related to COVID-19.
<input type="checkbox"/>	I was experiencing symptoms of COVID-19.
<input type="checkbox"/>	I was caring for an individual who was subject to a federal, state, or local quarantine or isolation order related to COVID-19, or who was advised by a health care provider to self-quarantine due to concerns related to COVID-19.
<input type="checkbox"/>	I cared for my son/daughter whose school or place of care has been closed, or whose child-care provider is unavailable, due to COVID-19 precautions.



**SECTION 2 – CALIFORNIA COVID-19 SUPPLEMENTAL PAID SICK LEAVE**

**Check in left column all qualifying reasons for leave request.**

- ☐ 1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.  
A. Provide Government Agency that issued the order:  
\_\_\_\_\_ Federal Centers for Disease Control and Prevention (CDC)  
\_\_\_\_\_ State of California  
\_\_\_\_\_ County of Los Angeles  
\_\_\_\_\_ Other: \_\_\_\_\_

- ☐ 2. I have been advised by a health care provider to self-quarantine or self-isolate due to concerns related to COVID-19.  
A. Provide name of health care provider that advised you to self-quarantine or self-isolate:  
\_\_\_\_\_

- ☐ 3. I am prohibited from working by my departmental supervisor or manager due to health concerns related to the potential transmission of COVID-19.  
A. Provide name of supervisor or manager who indicated you may not work:  
\_\_\_\_\_

**Certification:** I am unable to work or telework and hereby request leave/approved absence from duty as indicated above and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my employing department's procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if required) and that falsification of this form may be grounds for disciplinary action, including discharge. I understand and fully acknowledge that, should an overpayment occur, I am required to repay the number of hours of paid leave I was not entitled to.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

***Privacy Act***

Section 6311 of Title 5, United States Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: to the Department of Labor when processing a claim for compensation regarding a job connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the County of Los Angeles Department of Human Resources or the Chief Executive Office when the information is required for evaluation of leave administration; or the Internal Services Department in connection with its responsibilities for records management



**FOR DEPARTMENTAL USE ONLY**

☐ Approved as requested by employee.

☐ Request is approved with the following modification(s):

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☐ Request is NOT approved because:

☐ This employee did not provide a qualifying reason covered by Labor Code § 248.1.

☐ This employee was previously provided with COVID Paid Leave hours for one of the qualifying reasons covered by Labor Code § 248.1 and has exhausted those hours.

Other:

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\_\_\_\_\_  
DEPARTMENT HEAD/DESIGNEE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DEPARTMENT HEAD/DESIGNEE NAME